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ABSTRACT

An intense preoccupation with death is evident in the Mexican culture's pre-Columbian art, myths, and religion. This preoccupation is still present in the urban Mexican American. A death in a Mexican family causes a set of emotions and events quite different from those seen in an Anglo family. The Mexican reaction to death is such that if the full process of mourning is not completed, it is possible that the survivors may find it so difficult to return to their "normal" life that they cease to function. Death and lack of resolution through mourning and grief are among the many events which may lead to a "nervous breakdown". The Xipe-Totec Clinica de Salud Mental, which has been in operation since November 1971 at Metropolitan State Hospital in Norwalk, California, uses these feelings to develop a ritual-drama to facilitate catharsis in Spanish-speaking mental patients. The patient is placed in a familiar cultural setting where the decorations and furnishings, language, music, social activities, and customs are such as to relax him and remove additional stress caused by conflict with the Anglo culture. The goal is to bring about a collective response in the group. Strong expression of emotion is the most important element in the "funeral ceremonies". Collective mourning for the dead is essential if the technique is to work therapeutically for the patient. (Author/NQ)

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I. Aguilar and V. N. Wood

ABSTRACT

One of the most striking characteristics of Mexican culture is an intense preoccupation with death. This preoccupation is evident in pre-Columbian art, myths and religion, and is still present in the urban Mexican-American. The authors describe how these feelings have been used to develop a ritual-drama to facilitate catharsis in Spanish-speaking mental patients.

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Aspects of Death, Grief and Mourning in the Treatment of Spanish-speaking Mental Patients

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INTRODUCTION

The Greater Los Angeles Metropolitan Area has the largest Spanish-speaking population in the United States. Most of this population is of Mexican descent, but it also includes a substantial number of Cubans, Puerto Ricans, and people from other parts of Latin America. Mexicans had settled this area before the advent of the English-speakers, and have always formed a significant percentage of the population, maintaining their unique culture and language. The settlement by the gringos brought with it a history of prejudice, mistreatment and violence whose effects are still very much evident today in the mixed reactions of the Spanish-speaking citizens.

Partly because of this feeling of marginality, a segment of this Spanish-speaking population eventually finds its way into the State Hospitals, where there is a lack of adequate treatment, prejudice and misunderstanding. The failure to find meaningful ways to educate the Spanish-speaking population is reflected in the lack of trained Spanish-speaking personnel in the public institutions, with the result that Spanish-speaking clients most often receive little or none of the aid to which they are entitled as citizens. In the State Hospitals, they are most often medicated and left alone until their stay expires or until they leave voluntarily. Psychiatric treatment for the Spanish-speaking patient is practically non-existent.

In a State Hospital for the mentally ill, mental illness is usually viewed within the framework of a particular method or technique, and the therapy prescribed is based primarily on the particular psychoanalytical school in which the social

worker has been trained. We often find that these techniques are not effective in the treatment of the culturally different patient and that they must be modified in order to meet the needs of the patients. Since, as Slavson points out, "the individual cannot be understood apart from his family and social culture" ([14], p. 12), then it is not only necessary to understand the etiology of the illness, but of the utmost importance to understand the cultural perception of the patient regarding his own illness. Even if the overt symptoms can be classified within some classical mental illness framework, the things the patient feels are going to help him get well, and the cultural values the patient brings with him to the Hospital must be understood before the psychotherapeutic approach can be determined.

Friedlander states it this way: "In working toward the social adjustment of the individual and the group, Social Work needs to consider the cultural environment from which the individual clients or group come. These values may not be the same as those of the social worker himself or of a majority group that determines the policies of social work practice through its organization." ([6], pp. 9-10). This concept becomes more important when one deals with patients who are of a definite and unique different cultural background than the worker. Their values, their attitudes, their perception of themselves in relation to their families, the society, and the institution itself, must be taken into account. Not until then can one begin to tailor a therapeutic plan for the patient to provide meaningful and effective treatment which will return him to the community as a responsible person once again.

Metropolitan State Hospital in Norwalk, California, has inaugurated a program for Spanish-speaking patients (the first of its kind in California, and in the United States) in which the total treatment plan -- including the furnishing and decoration of the ward, the nature of the recreational activities, as well as the psychiatric treatment -- is based primarily on the healthy characteristics of the Mexican culture, and also on the Latin culture in general. This program, the Xipe-Totec Clinica

de Salud Mental (see Aguilar, [1]), has been in operation since November 1971, and is proving itself quite valuable. The program is still considered to be in an experimental stage, even though the early throes of initial organization are over and daily routines have become fairly well established. Although the program staff are all Spanish-speaking and (except for one person) all of Mexican descent, there are many aspects of the manifestation of mental and emotional disorders peculiar to Spanish-speakers about which we are still learning, researching, and concerning which treatment methods are still being devised.

In order to describe these methods, we will from this point on restrict our discussion to aspects of the Mexican culture. We do this because the large percentage of the patients in this program are either Mexican or of Mexican descent. The daily population of the Clinic varies between 45 and 50 patients, of whom rarely more than 10 are of other-than-Mexican descent. We have found, however, that although these processes are drawn from the Mexican culture, all patients respond to them. We attribute this response to the unifying effects of the Spanish Catholic religion throughout Latin American.

DEATH and MOURNING

Among the many events that may lead to a psychotic break, or 'nervous breakdown,' is death and the important matter of the resolution of mourning and grief. There is no culture for which death is not one of the most significant events; however, the cultural ways of handling this highly stressful situation vary immensely, and (as we might expect) a death in a Mexican family causes a set of emotions and events quite different from those seen in an Anglo family.

Weisman describes the Anglo situation: "American culture, confronting death, has attempted to cope by disguising it, pretending that it is not a basic condition of life. . . . The unharpy result, all too often, is that the dying patient is left to die emotionally and spritually alone. We do not even permit him

to say goodbye" ([20], p. ix). He further says, "Death is either an idolized extension of terrestial life as we know it, or it is simply complete and unambiguous extinction" ([20], p. 1).

In contrast, for the Mexican death and the dead are treated with much respect -- for the dead are always with us. The Mexican inherits a long tradition that this life is merely an intermediate step on the way to another life -- perhaps not too much different from this one, perhaps better. There is an inevitability about this road from birth to death. Even if there is no longer a belief in the gods that controlled life according to the day of one's birth, there remains an implicit feeling that one can do little but live one's days -- working, raising children, working, praying, working. Always working. La vida es trabajar y poco gozar. (Life is work, with little pleasure.)

Perhaps the best expression of this fatalistic feeling towards life/death is given in an ancient Aztec poem:

"We only came to sleep,
we only came to dream;
it is not true, it is not true
that we came to live on the earth.

We become the green growth of spring;
our hearts will again revive,
they will again open their petals;
but our body is like a rosebush:
it gives a few flowers and withers."

Although this poem is not generally known to most Mexicans, it expresses very well the Mexican attitude towards death. This world is transient; life is merely a passage from one state-of-being to another; there is something of greater significance for us somewhere. By 'somewhere' is not meant merely the Christian concept of an everlasting life, but that in this cosmos there must be a greater meaning and that death is merely a vehicle, a marker, on the road we must travel to achieve whatever it is that awaits us. However, the Mexican handles this fear and uncertainty about death differently from the Anglo-Saxon. As Octavio Paz

describes it: "For the resident of New York, Paris or London, death is a word that is never spoken because it burns the lips. In contrast, the Mexican frequents death, makes fun of it, caresses it, sleeps with it, fetes it; it is one of his favorite games and his deepest love. . . Our songs, verses, fiestas and popular sayings demonstrate unequivocally that death does not frighten us because 'life has cured us of fears.'" ([13], p. 52)

As with most cultures, the Spanish-speakers believe that one should not speak ill of the dead. There is a belief, often verbalized, that the dead (now possessed of supernatural powers) remain close enough to hear our words and may revenge themselves upon us. For this reason the Day of the Dead, November 2, is a very special day in Mexico. It is not a 'trick or treat' day for children, nor can it be compared to Memorial Day, Veterans' Day, nor any other United States holiday that presumably pays honor to the dead. For, where these days have become for Americans merely days on which one does not work, and on which we have such events as the Indianapolis races, for the Mexicans November 2 is a very serious and meaningful ceremony carrying implications of appeasement, forgiveness and repentance. On this day altars are erected in homes, and food is set out to nourish the dead who may choose to return and visit their families. Paths to the house are strewn with marigolds to lead the dead back to their homes. However, the family does not necessarily stay in the home to greet the dead; they might go to the cemetery where they decorate the tombs, bring food to the graves, and sit and eat, pray and commune with the dead. For the dead are always with us; and therefore one must respect and care for them, even if it is only once a year. Failure to do so brings fear, remorse, shame, and ultimately disgrace for the whole family.

This celebration of the Day of the Dead can perhaps best be described as a celebration of life-in-death. The figures associated with this day -- the candies, breads, toys, papier-maché figures -- are all death figures (skulls, bones, skeletons), but all are engaged in activities of life. They dance, sing, eat; there is even a string-operated toy which is a skeleton that sits

up and drinks a tequila when the string is pulled (see [11], [12]).

When a person dies, a two-fold process is set in motion: there are the activities connected with the honoring of the dead and proper burial, and there are the activities reaffirming the survivors' position in the world of the living. In some parts of Mexico, the Indians celebrate a death with a big fiesta. If you ask them why they have music, why they have dancing, why all the celebration, the answer is always that they are celebrating the fact that this person has gone beyond, that he no longer has to be in this world where everything is sorrow and unhappiness, and therefore why be sad because that person has died? On the contrary, we should be sad because we remain, and glad because that person has gone -- gone to something better than what we have here today.

In urban Mexico, when a person dies, he is removed to a funeral home as soon as possible. The family unites to provide a constant watch over the body as it lies in state (if the family is poor, the body will lie in state in the largest room in the house, rather than in the funeral parlor), and a schedule is arranged so that someone is always with the bereaved ones at home. In the neighborhood, and among all the friends and acquaintances of the family, continual visits are made to the bereaved household, bringing food, drink and other necessities, and sitting with the family to offer condolences and to talk about the deceased. The atmosphere is quiet, but not funereal. People may reminisce about the dead person in many ways -- tell amusing, but not irreverent, stories, discuss his personality traits, say anything that comes to mind, so long as he does not speak ill of the dead. Family, friends and acquaintances are all present at the burial, after which there is again a period of a week or so during which there is much visiting to offer condolences. During this period, the family is again supported by friends and neighbors, in that food and drink is supplied by those who sit with the family and assist them in receiving the visitors. After this, life returns to the normal routine. Widows and widowers are expected to wear some sign of mourning for 6 months to a year; sons and daughters,

brothers and sisters, fathers and mothers, may return to their daily routine more rapidly. Widows and widowers are expected to refrain from social activities which may lead to courtship and marriage for at least 6 months, and preferably a year.

We have divided the mourning process for persons of Mexican descent into eight stages, beginning with (1) the death of a significant person, followed by (2) depression in the bereaved, and (3) the initiation of the mourning process -- consisting of (a) the wake (el velorio) in which friends, neighbors, family and others share in the collective mourning for the dead, emphasizing his good qualities only, and (b) the lying-in-state (la tendida) in which members of the family attend the body. This portion of the death ritual lasts from 36 to 48 hours following the death. The wake and the lying-in-state initiate (4) the acceptance of reality (i.e., the loss of the loved one) and prepare the bereaved for (5) the burial, in which process there is a collective acceptance of reality in that family, friends, neighbors, and acquaintances again unite with the bereaved at the graveside, validating the loss. This ceremony usually takes place on the second day following the death. After the burial, there is often (6) a second depression, during which the individual becomes aware of unresolved feelings of hostility towards the dead and feels guilty for being aware of the bad qualities of the dead. The social way of handling this guilt is through (7) the collective condolences during the week or so following the funeral, during which friends, neighbors, family again visit with the bereaved, strengthening his ties with the living and reinforcing (8) final acceptance of reality and lifting of the depression. Remaining feelings of guilt and hostility are handled during the annual visit to the graveside on the Day of the Dead.

For the Mexican-American, and for the Mexican immigrant, part of this process is often missing in the American funeral ritual. Both the Mexican-American and the Mexican immigrant live closely with death. When a member of the family is sick or ailing, he is not bundled off to a hospital and forgotten; in fact, in Mexico, the hospitals provide rooms where the patient's family

can stay and be with him during his entire illness. Thus, when a member of the family dies, some or all of the family has been with that person during the entire duration of the final illness. In the case of death by accident or death far from the family, part of the family's guilt and remorse will lie in the fact that the person died alone, away from those close to him. This feeling is enhanced in the United States during a terminal illness requiring hospitalization, for hospitals restrict hours of visiting and number of visitors, thus depriving the families of the opportunity to face the reality of approaching death and to make their own final peace with the dying person.

The Mexican awareness of 'the grim presence of death' extends to other areas than just the death of one near to him. For the Mexican immigrant, there is a period of mourning for the loss of his native land very similar to the mourning for a dead person. It is very easy for a person of Mexican descent to imagine the loss of something important, the lack of ability to function in accordance with cultural norms, as a death-like process -- the death of a part of him so that he cannot function in the prescribed way.

HOSPITAL SETTING

The problems that bring a person of Mexican descent to the mental hospital as a patient are fundamentally no different than those of non-Mexican patients. The difference lies in the Mexican concept of male and female roles, importance of family, importance of work -- which is to say that, even though the problems of a Mexican and a non-Mexican may be the same, the signs and symptoms that signal the fact that the person is not functioning may be very different for a person of Mexican descent and one not of that descent. In addition, the Mexican reaction to death is such that if the full process of mourning is not completed, it is possible that the survivor(s) may find it so difficult to return to their 'normal' life that they cease to function. Even more, once the stress process is begun, cultural differences may act to aggravate the situation (see Spradley, [16]).

"A situation is potentially stressful when a reorganization of role relationships and a re-allocation of social role functions must be made in an on-going primary group. Accustomed and habitual modes of adaptation must, under such circumstances, be modified." ([6], p.52) Thus, the overall purpose in the planning of the Xipe-Totec Clinica de Salud Mental is first to place the patient in a familiar cultural setting where the decorations and furnishings, language, music, social activities and customs are such as to relax the patient and remove additional stress caused by conflict with the Anglo culture. Under these conditions, the patient is far more willing to trust the ward personnel and discuss the problems that brought him to the hospital. This trust in the personnel is essential before the therapist can elicit the information that will enable him to evoke the necessary responses in the individual patient and in the group as a whole.

Catharsis is one of the most important elements in a psychotherapeutic relationship, and probably one of the most difficult responses to elicit freely in a patient. Although this process can be triggered in Anglos through well-established methods and techniques, it is not easy to apply to persons of Latin extraction, since the Latin character is not so 'open' as is the Anglo-Saxon, thus making it very difficult for the orthodox therapist to release an emotional outburst in the Latin patient. The problem is compounded if the persons under therapy are not English-speaking, and further compounded if the therapist knows little or nothing about the cultural background of these patients. In our experience at Metropolitan State Hospital, we have utilized many culturally-oriented techniques which elicit the catharsis.

However, to produce only the emotional catharsis is not the goal in itself, but rather the goal is to bring about a collective response in the group. As Yalom ([21], p. 72) says, "Catharsis -- the expression of a strong emotion -- is a valuable part of the curative process, but not a goal in itself. Strong expression of emotion enhances the development of cohesiveness." This is the most important element in the 'funeral ceremonies' conducted at the Xipe-Totec Clinc in order to help patients resolve the mourning fixation.

THE RITUAL-DRAMA

As we have mentioned before, collective mourning for the dead is essential if the technique is to work therapeutically for the patient. Whenever this technique is to be applied for the benefit of a patient, the Clinic team first discusses the indigenous cultural background of the patient, along with any other important facts about him which may be pertinent. When the time is ripe for the activity, the stage must be set; that is, the patient and the group must be prepared to participate and derive therapeutic benefit from the ritual.

When we call this procedure a ritual, we mean just that: this technique must be treated with a great deal of respect and mysticism if it is to produce the desired results. First the mood must be established in all patients by some means familiar to them, appropriately laden with cultural significance and ritualistic meaning. The reading of selected poetry dealing with mother, child, or the dead has been found to be particularly effective. Gustavo Adolfo Becquer's "Dios mío, que sólo se quedan los muertos" (Dear God, how lonely are the dead!) has always produced the desired reactions.

However, the procedure may start in a variety of ways. Occasionally the situation presents itself spontaneously -- i.e., it is the patient himself who introduces the subject of death; sometimes a gloomy day has already made its contribution to establishing the setting. Whatever the initiating conditions, the enactment never takes place abruptly; there is always a set of preparatory statements which set the scene. Besides the reading of poetry, the therapist might encourage participation by such statements as "What would you say to your father (mother, husband, etc.) if he were here now?" "What would you have said if you could have been with him when he died?", etc. This preparatory period may be quite brief (when the group is very receptive), or may be relatively prolonged. It rarely lasts longer than five minutes.

In the case of a spontaneous enactment of the ritual, it is during the exploratory/preparatory period that it is determined

whether the dead person will be male or female. When the ritual has been planned beforehand, the preparatory stage tends to be shorter. However, it is during this period that the decision is made whether to have a velorio or a tendida. Both situations require that one of the patients take the role of the corpse. However, one ceremony (the velorio) terminates with the closing of the coffin and the funeral procession; the other consists of having the target patient kneel by the body and say those things left unsaid during the actual event, after which all participants return to their places.

The exploratory/preparatory period is followed by a very rapid scene-setting. As quickly as possible a blanket is spread on the floor, the person selected as the corpse lies down on it, a second blanket is spread next to it which will later be used to cover the 'corpse' when the 'coffin' is closed. Candles are lit and placed at the head and foot of the bier; the lights are dimmed. The scene is set.

The therapist then says, "There is your father (mother, husband, wife, etc.). Go to him. Say goodbye to him. Tell him all the things you never said", etc. This is the moment of catharsis. The patient approaches the bier and (usually) kneels beside it. As much as possible at this point, the therapist lets the scene proceed spontaneously; however, it may be necessary for the therapist to intervene by encouraging the patient to speak -- even to the extent of standing behind him and speaking for him. This is a very delicate time in the ritual, for the real world situation is one in which revealing personal feelings of hostility, anger, or hate, would be forbidden; at the same time that the situation has been set up to evoke memories and feelings about the dead person, the situation is one for which the traditional appropriate behavior prohibits the very catharsis the therapist is seeking to achieve. If the situation is not handled very carefully at this moment, the entire mood may be broken and the opportunity lost. The therapist must be very sensitive to the mood of the group and to the target patient if the ritual drama is to be successful.

When successful, reactions have sometimes been quite

dramatic. One woman collapsed in a faint on the body of her mother; one young man, who had previously been resistive and unresponsive, cried bitterly over his mother, who had died while he was in prison; one young girl became nearly uncontrollably hysterical at the burial of a father. This last case was completely spontaneous, as she was not the target patient and our knowledge of her case did not indicate the possibility of such a reaction.

The group reaction reinforces the emotional content of the ritual. There is always several women who quite spontaneously take on the role of mourners, kneeling around the body and reciting prayers. Men, too, seem to fall into appropriate roles. To an observer, it almost seems as if a family materializes for the patient; one can almost identify uncles, aunts, sisters, brothers, emerging from the group to comfort and support the grieving person.

In the case of the velorio, after the patient has said everything he wants to, he closes the coffin by covering it with the second blanket. A funeral procession is formed, the casket being represented by a table. Two pallbearers carry the casket and the procession moves to the end of the hallway, where the 'burial' takes place and flowers are put on the grave. While the burial is taking place, the velorio scene is cleaned up, lights are turned on again, the 'corpse' returns to the group. The procession returns from the graveside to resume daily activities. Life must go on.

Clinic activities are resumed at this point, but even then in a way consistent with the events that have just occurred. This is usually the time for the coffee break, giving everyone a chance to relax from the intense emotions just released. Yet the setting also corresponds to a part of the mourning process outlined earlier -- the period of collective condolences. The group is still considerate of the bereaved person at the same time that each person begins to resume his role among the living -- the group pressure thus acts to reinforce the bereaved's acceptance of his loss and return to his own life.

The result of participation in this ritual have often

been pronounced. Very often a neurotic depression becomes a healthy, normal depression, and after a day or so of this depression, the patient's acceptance of his current situation becomes evident -- in facial expression, bodily attitudes, as well as in verbal responses. Upon asking the patient how he feels about the dead person, the response is a normal, non-neurotic, "He's dead now."

One fourteen-year-old girl had been having hallucinations about her father. He had been appearing to her telling her that she was 'bad.' The events following the father's death were such that the girl had developed strong feelings against her mother and was very resentful of the changes that had taken place since then. The most violent change was that the mother had moved the family from Mexico to the United States and the girl was undergoing the physical and emotional changes of adolescence in strange surroundings, besides having unresolved feelings of grief and anger at the loss of her father. During the velorio, she slapped her "father's" face saying, "You were bad. You drank. You left us alone." Later she forgave him, and asked his forgiveness, closed the coffin and said, "descanse en paz" (rest in peace). She has had no further hallucinations of her father.

We have used this ritual in even more symbolic ways -- to bury undesirable things, such as one's past life -- and have also found it effective. The effectiveness lies in the symbolism of the Mexicans' pervasive respect for death and the significance of the burial -- the mourning, the forgiveness, the interment, the final blessing -- the ultimate acceptance of the ending of one part of life and the beginning of another.

We do not claim that this ritual-drama solves all problems, for the conditions that cause a person to cease to function to the extent that he becomes a patient in a mental institution are not simple. However, when there is reason to suspect that one of the precipitating conditions is unresolved feelings about the death of someone close, we have found that participation in this ritual-drama frequently has a significant curative effect on this aspect of the problem.

CONCLUSION

Although the setting for the treatment of the Spanish-speaking person in this instance takes place in a very controlled environment (i.e., the State Hospital), it is clear that it is very important for a professional -- be he social worker, psychologist, or any other health service person -- to consider that cultural differences are very much related to the patient's conception of his function, his relations, and his psychic elements and self-image. Although his psychic elements are no different from any other person's, the expression of these elements vary greatly according to his cultural background. Therefore, for the therapist treating this type of patient, it means that he must first understand his familial culture, the patient's own world, and his national culture. Because the patient is expected to return to his own social setting and family it is of utmost importance that we learn about these aspects of his life and include them in our therapeutic plan. Gordon Hamilton sums it up this way: "A person can be well-adjusted in a closed culture in which traditional and dogmatic influences perform the functions of a collective superego or conscience. Idealogies to which people completely submit or which they completely incorporate into their lives seem to create a condition of tranquility for the individual. Dislocation without reference to cultural roots and customs makes for tensions, insecurity, and anxiety. No treatment goal can be envisaged which does not involve a value judgment which is itself culturally determined." ([9], p.)

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